Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services



BRISTOL HOSPITAL AND HEALTHCARE GROUP, INC. : Aetna Open Access® Aetna SelectSM - POS Plan

Coverage for: Individual + Family | Plan Type: EPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <u>www.HealthReformPlanSBC.com</u> or by calling 1-888-402-1243. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-402-1243 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 (Bristol): Individual \$250 / Family \$500. Tier 2 (Friends & Family): Individual \$1,000 / Family \$2,000. Tier 2 (Aetna): Individual \$2,000 / Family \$4,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Prescription drugs is covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Tier 1 (Bristol), Tier 2 (Friends & Family) & Tier 3 (Aetna): Individual \$5,000/ Family \$10,000.	The <u>out–of–pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out–of–pocket</u> <u>limits</u> until the overall family <u>out–of–pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premium</u> s, <u>balance-billing</u> charges & health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out–of–pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See <u>www.aetna.com/docfind</u> or call 1-888-402-1243 for a list of Tier 1 (Bristol) <u>providers.</u>	You pay the least if you use a <u>provider</u> in Tier 1 <u>Provider</u> (Bristol). You pay more if you use a <u>provider</u> in Tier 2 <u>Provider</u> (Friends & Family) or Tier 3 <u>Provider</u> (Aetna). You will pay the most if you use an <u>out-of-network provider</u> and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

		What You Will Pay				
Common Medical Event	Services You May Need	Tier 1 Provider (Bristol) (You will pay the least)	Tier 2 Provider (Friends & Family) (You will pay more)	Tier 3 Provider (Aetna) (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit	\$40 <u>copay</u> /visit	\$50 copay/visit	Not covered	None
	Specialist visit	\$25 <u>copay</u> /visit	\$55 <u>copay</u> /visit	\$65 <u>copay</u> /visit	Not covered	None
If you visit a health care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
Maria barra a tart	<u>Diagnostic test</u> (x-ray, blood work)	10% coinsurance	20% coinsurance	25% coinsurance	Not covered	None
If you have a test	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	20% coinsurance	25% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetnapharmac	Generic drugs	Copay/prescription, deductible doesn't apply: \$10 (retail), \$25 (mail order)	Not applicable	20% coinsurance with minimum & maximum/prescripti on, deductible doesn't apply: \$20 minimum & \$60 maximum (retail); \$100 copay/prescription (mail order)	Not covered	Covers 34 day supply (retail), 34-90 day supply (mail order), 90 day supply (in house). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred

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<u>y.com/standard</u>	Preferred brand drugs	Copay/prescription, deductible doesn't apply: \$20 (retail), \$50 (mail order)	Not applicable	30% coinsurance with minimum & maximum/prescripti on, deductible doesn't apply: \$40 minimum & \$120 maximum (retail); \$200 copay/prescription (mail order)	Not covered	generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics. Maintenance drugs- after two retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service
	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: \$35 (retail), \$87.50 (mail order)	Not applicable	30% coinsurance with minimum & maximum/prescripti on, deductible doesn't apply: \$60 minimum & \$180 maximum (retail); \$300 copay/prescription (mail order)	Not covered	Pharmacy or CVS Pharmacy or Bristol Pharmacy. Your prescription drugs will accumulate towards your Tier 3 (Aetna) out of pocket limit.
	Specialty drugs	Copay/prescription, deductible doesn't apply: \$35	Not applicable	30% coinsurance with minimum & maximum/prescripti on, deductible doesn't apply: \$30 minimum & \$300 maximum	Not covered	All prescriptions must be filled through Bristol Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	25% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	20% coinsurance	25% coinsurance	Not covered	None

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	Emergency room care	10% <u>coinsurance</u>	20% coinsurance	20% coinsurance	20% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	20% <u>coinsurance</u>	Non-emergency transport: not covered, except if preauthorized. Out-of-network emergency use paid the same as innetwork.
	Urgent care	\$20 <u>copay</u> /visit	\$55 <u>copay</u> /visit	\$65 <u>copay</u> /visit	Not covered	No coverage for non- urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	20% coinsurance	25% coinsurance	Not covered	None
110Spital Stay	Physician/surgeon fees	10% coinsurance	20% coinsurance	25% coinsurance	Not covered	None
If you need mental health, behavioral health, or	Outpatient services	Copay/visit: \$15 (office); \$10 (other outpatient services)	Copay/visit: \$40 (office); \$55 (other outpatient services)	Copay/visit: \$50 (office); \$65 (other outpatient services)	Not covered	None
substance abuse services	Inpatient services	10% <u>coinsurance</u>	20% coinsurance	25% coinsurance	Not covered	None
	Office visits	No charge	No charge	No charge	Not covered	Cost sharing does not
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	25% coinsurance	Not covered	apply for <u>preventive</u> <u>services</u> . Maternity care
If you are pregnant	Childbirth/delivery facility services	10% <u>coinsurance</u>	20% coinsurance	25% coinsurance	Not covered	may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special	Home health care	10% <u>coinsurance</u>	20% coinsurance	25% coinsurance	Not covered	120 visits/calendar year combined with private-duty nursing.

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health needs	Rehabilitation services	\$10 <u>copay</u> /visit	\$55 <u>copay</u> /visit	\$65 <u>copay</u> /visit	Not covered	60 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services.
	Habilitation services	\$10 <u>copay</u> /visit	\$55 <u>copay</u> /visit	\$65 <u>copay</u> /visit	Not covered	None
	Skilled nursing care	10% coinsurance	20% coinsurance	25% coinsurance	Not covered	120 days/calendar year.
	<u>Durable medical</u> <u>equipment</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	Limited to 1 <u>durable</u> <u>medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	10% coinsurance	20% coinsurance	25% coinsurance	Not covered	None
If your child needs	Children's eye exam	Not applicable	No charge	No charge	Not covered	1 routine eye exam/24 months.
dental or eye care	Children's glasses	Not applicable	Not applicable	Not covered	Not covered	Not covered.
	Children's dental check-up	Not applicable	Not applicable	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs Except for required <u>preventive</u> <u>services</u>.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)

- Acupuncture 20 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery Limited to Tier 1 (Bristol) providers only.
- Chiropractic care 15 visits/calendar year for Tier 2 & Tier 3 (Aetna) only.
- Hearing aids 2 hearing aids/24 months for children up to age 12 for Tier 2 & Tier 3 (Aetna) only.
- Infertility treatment For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing Included as part of home health care.
- Routine eye care (Adult) 1 routine eye exam/24 months for Tier 2 & Tier 3 (Aetna) only.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the <u>plan</u> at 1-888-402-1243.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- If your coverage is a church <u>plan</u>, church <u>plans</u> are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance</u> <u>Marketplace</u>. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your plan documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-888-402-1243. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

Does this plan meet Minimum Value Standards? Yes.

If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$10
Coinsurance	\$1,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,420

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ Specialist copayment	\$2
■ Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Diabetic supplies (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
Copayments	\$800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,070

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$250
Specialist copayment	\$25
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$90
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$540

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-402-1243.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-888-402-1243.

Albanian - Për shërbime përkthimi falas për ju, telefononi 1-888-402-1243.

Amharic - የቋንቋ አባልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-402-1243 ይደውሉ።

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 1-888-402-1243

Armenian - Անվձար լեզվական ծառալություններից օգտվելու համար զանգահարեք 1-888-402-1243 հեռախոսահամարով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-402-1243 tanpa dikenakan biaya.

Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-888-402-1243.

Bengali-Bangala - আপনাকে বিনামূক্যে ভাষা পবিক্ষাি পপকে হক্ষ এই নম্বকি পেব্যক ান েরুন: 1-888-982-386|

Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-402-1243.

Burmese - သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မႈမ်ား ရရွိႏုိင္ရန္ 1-888-402-1243 သို႕ ဖုန္းေခၚဆုိပါ။

Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-402-1243.

Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-402-1243.

Cherokee - GYOJ SOHAOJ OGOLOJA L ALOJ IGEGMUT PAR OPAPAROJ OGOLOJA C ALOJ IGEGMUT PAR OPAPAROJ OGOLOJA SOHAOJ O

Chinese - 如欲使用免費語言服務, 請致電 1-888-402-1243.

Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-402-1243.

Cushite - Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-402-1243.

Dutch - Voor gratis toegang tot taaldiensten, bell 1-888-402-1243.

French - Afin d'accéder aux services langagiers sans frais, composez le 1-888-402-1243.

French Creole - Pou jwenn sèvis lang gratis, rele 1-888-402-1243.

German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-402-1243 an.

Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό

1-888-402-1243.

Gujarati - તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોોંર્ માટે, કોલ કરો1-888-402-1243.

Hawaiian - No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-888-402-1243. Kāki 'ole 'ia kēia kōkua nei.

Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,1-888-402-1243 पर कॉल करें।

Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-402-1243.

lgbo - lji nwetaòhèrè na oru gasi asusu n'efu, kpoo 1-888-402-1243

llocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-888-402-1243.

Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-888-402-1243.

Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-402-1243.

Japanese - 言語サービスを無料でご利用いただくには、1-888-402-1243 までお電話ください。

Karen - လာတါကမၤနာကြိုဉ်အတါမာစာၤအတါဖုံးတါမာတဖဉ်လာတအိဉ်ဒီးအပူးလာကဘဉ်ဟူဉ်အီးအဂ်ီးဘဉ်နှဉ် ကိုး 1-888-402-1243 တက္၊

Korean - 무료 언어 서비스를 이용하려면 1-888-402-1243 번으로 전화해 주십시오.

Kru-Bassa - Mì dyi wudu-dù kà kò dò bě dyi moú ń nì Pídyi ní, nìí, dá nòbà nìà kε: 1-888-402-1243

بۆ دەسىيىر اگەيىشتن بە خزمەتگوز ارى زمان بەبئى تىپچوون بۆ تۆ، يەيوەندى بكە بە ژمارەي 1243-402-888-1

Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ1-888-982-3862

Marathi - कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-888-402-1243 वर फोन करा.

Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-888-402-1243.

Micronesian-

Pohnpeyan - Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-888-402-1243.

Mon-Khmer, ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888- 982-3862។

Cambodian -

Navajo - T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó kojj' hólne' 1-888-402-1243.

Nepali - निःशुल्क भाषा सेवा प्राप्त गर्न 1-888-402-1243 मा टेलिफोन गर्नुहोस् ।

Nilotic-Dinka - Të koor yin weër de thokic ke cin wëu kor keek tënon yin. Ke col koc ye koc kuony ne nomba 1-888-402-1243.

Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-888-402-1243.

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-402-1243.

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1243-402-1243 تماس بگیرید.

Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-402-1243.

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-402-1243.

Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-402-1243 'ਤੇ ਫ਼ੋਨ ਕਰੋ।

Romanian - Pentru a accesa gratuit serviciile de limbă, apelați 1-888-402-1243.

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-402-1243.

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-402-1243.

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-888-402-1243.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-888-402-1243.

Sudanic-Fulfude - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-888-402-1243.

Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-888-402-1243.

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-402-1243.

Telugu - మీరు బాప్ల సేవలను ఉచితంగా అందుకునందుకు. 1-888-402-1243 కు కాల్ చేయండి.

Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-402-1243.

Tongan - Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-402-1243.

Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-888-402-1243.

Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-402-1243 numarayı arayın.

Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-402-1243.

بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 3862-982-988-1 پر بات کریں۔

Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-402-1243.

Yiddish - 1-888-402-1243 צו צוטריט שּפרַאך בַאדינונגען אין קיין פרייַז צו איר, רופן

Yoruba - Lati wonú awon ise èdè l'ofe fun o, pe 1-888-402-1243.